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HEALTHIER TOGETHER: WHAT'S NEXT IN MEDICINE

Joanna Crangle: What are some main points that you'd like to share about healthcare and your specialty?

Dr. David Stern: For us, the effort in addiction medicine or substance use disorder is important because there aren't a lot of physicians in this region who are trained in that. Our belief is, the real people who should care for patients who have substance use disorder are the primary care physicians. Those are the docs who have contact with the patients.

With children of high school and college age, 50 percent report unhealthy or risky substance use, in the adult population about 2.5 percent have substance use disorder, it's a lot of folks. It's good that we have specialists, but the trick is to disseminate the knowledge, and this has to be a disease treated by the primary care folks. Our goal at UT Health Science Center is to have a hub of expertise in addiction medicine. We have an addiction medicine fellowship and it's the only one in Tennessee, though Vanderbilt will start one up now. That creates addiction medicine specialists for the region.

"40–60 percent of people are going to relapse."

DR. DAVID STERN, vice chancellor for Health Affairs for Statewide Initiatives at UTHSC

But our goal is to make it so more folks can treat patients with addiction. We look at addiction as a chronic, relapsing disorder; 40–60 percent of the people are going to relapse. So we look at how to chip away at that through research and how to disseminate the knowledge. We're a hub of expertise, but for the purpose of reaching out to patients, and especially other practitioners. We're doing that. We're part of the Shelby County Addiction Plan. We're doing that with the state, and we're especially interested in the vulnerable populations

MODERATOR

Joanna Crangle is market president and publisher of *MBJ*, which she joined in 2006 as circulation/marketing director. She was promoted to advertising director in 2008 and to her current position in 2014. The native Memphian and grad of the University of South Florida serves on the Economic Club of Memphis board and has been involved with Rotary Club of Memphis and Sales and Marketing Society of the Mid-South.

PANELISTS

David M. Stern, MD is the vice chancellor for Health Affairs for Statewide Initiatives at the University of Tennessee Health Science Center. He served six years as the Robert Kaplan Executive Dean of the UTHSC College of Medicine. He is the founder of the Center for Addiction Science at UTHSC, which was named the first Center of Excellence in Addiction Medicine in the country in 2016. He has been a tireless advocate for improving medical education.

Lisa Smith, CEO of Compass, is a Licensed Clinical Social Worker and has 12 years of experience in behavioral health. Before taking on the role of the CEO, Lisa served as the Clinical Program Director and Assistant Administrator. Prior to coming to Compass in 2012, Lisa was a Clinical Program Consultant for an in-home program in Tennessee and North Mississippi. Lisa has dedication and passion for maintaining the quality program and culture of safety at Compass.

Sunder Krishnan, MD has over 20 years of experience in patient care and recently joined Regional One Health to launch a pain treatment center. Fellowship-trained and board certified in Anesthesiology and Pain Medicine, he has received numerous awards, including the "Most Compassionate Doctor Award" for six consecutive years and a 2016 honor for "American's Most Honored Professionals – Top 1%."

Kevin T. Foley, MD is a professor of neurosurgery, orthopaedic surgery and biomedical engineering at the University of Tennessee Health Science Center. He is also the chairman of the board of Semmes Murphey Clinic and chairman of the board and medical director for the Medical Education & Research Institute.

Jeremy Pitzer earned his MSW from the University of Illinois and is Tennessee LCSW. Jeremy has dedicated his career to helping children and adults recover from mental health and addiction problems. Jeremy has extensive experience across the behavioral health system with a passion for treating trauma and co-occurring disorders.

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Lisa Smith: We focus on how the various systems that impact the stability of children and adolescents and their substance abuse. We work with schools and family systems. And a lot of the time, when a kid comes in contact with the Department of Child Services or juvenile court, it's the first time they get identified for treatment.

Often times with kids who have significant substance abuse, there is discord in the family or school system. In treatment, families learn how to acclimate to the behaviors and the needs of the kids with substance abuse. For kids, it's about access; whatever they can get their hands on— from peers or mom and dad's and even grandma's medicine chest.

We focus on assessment early on—trauma screening and substance screening. Based on those, we determine a treatment model. About 80 percent of these kids have had some sort of trauma. Typically, we try to address both in treatment. We utilize Trauma-Focused Cognitive Behavioral Therapy (TFCBT) and Seven Challenges treatment models. Seven Challenges is on the SAMSHA national registry and geared toward kids who have significant trauma and substance use. We look at how we can rebuild their ability to enter systems, like school, and getting them acclimated to and surrounded by positive peers and positive support.

Dr. Krishnan: We have to educate our patients about their condition, noninvasive treatments, medications and establish a diagnosis before prescribing. We have to practice safe prescribing practices and monitor patients closely. A multi-disciplinary approach is often required in treating patients.

Education, education, education. That's the key for patients and physicians. Frequently, patients don't know why they're taking medications. They just take them. We have to sit down and explain why a medication is being prescribed, the potential for addiction and then patients will be more conscious of why and when they should take them.

Dr. Foley: Spinal neurosurgery is my expertise, and I have developed a number of different devices and approaches for minimally invasive spinal surgery.

Surgery induces pain. One rationale for minimally invasive surgery is to diminish the pain of surgery. When we intervene in spinal surgery, typically it's to control pain. Other reasons include such things as spinal injury, loss of neurologic function, and infection. But the primary reason people undergo spinal surgery is to control pain.

Surgery is looked upon as a last resort. Initially, conservative care is utilized. However, timely surgical intervention rather than prolonged medication use can be advantageous. Back pain is the second most common reason patients visit a primary care doctor. And it's the most common reason for lost work days. It has huge societal implications. It's a maj0r cause of productivity loss for businesses.

Jeremy Pitzer: When a patient comes to us, they have a significant impairment in their life; significant mental health disorder on top of substance abuse—major depression, bipolar, some psychosis, prevalence of suicide.

Our viewpoint is to address mental health and addiction and get to the underlying causes. Research indicates that a lot of this has roots in childhood trauma that impacted development. We treat the whole person—cognitive and social aspects—to deal with unresolved trauma. It's easily identified: In the patients we work with, the rate of childhood trauma is 50 percent in men, and 70 percent in women. It's that high.

Relapse rates are over 50 percent. To decrease that rate, we have to address the traumas on top of their addiction needs and general mental health needs.

Crangle: Loss of productivity is a big challenge for businesses. How does overall health, pain and mental health impact business owners and decision-makers?

Dr. Stern: Substance abuse disorders in Tennessee are a cause of being unprepared. You've heard of workforce preparedness, it's a cause of the opposite. Unfortunately, we deal with Employee Assistance Programs (EAP), they are all run in a confidential way, but in some programs when someone has substance abuse disorder, the employer fires them.

Education is important. If productivity falls, someone should help me recognize it. We need to recognize that substance abuse disorder is important and has other ramifications. Employees think, 'If I get fired, I won't have insurance. And the type of treatment I can get changes.'

The take home message is: If patients have substance use disorder or mental health issues, if you ignore these problems, you don't have a productive workforce.

Crangle: Looking at a person as a whole was an innovative perspective. What else can help individuals adjust to impending challenges?

Smith: This goes back to the education piece. Parents take for granted that kids will always make the right decisions, but parents need to be mindful of monitoring peers and social media.

With social media, kids should not privacy. And when parents read posts, you can see what the child has access to and monitor before it becomes a crisis situation.

Peers are a primary source for decision-making. Who do kids surround themselves with? Parents need to focus the supervision to reduce risk factors in kids getting into substance abuse or being exposed through peers.

Dr. Foley: Timely and appropriate intervention are huge factors. If you have chronic spinal instability and you're attempting to treat it with pain meds: a. you're not getting to the heart of the problem, and b. continued medication use puts patients at risk for tolerance issues and they need more and more medication to treat their pain.

Intervening and addressing that problem with appropriate medical or surgical care can eliminate that need for chronic pain medication and lessens the risk of creating someone who's chronically dependent on pain meds.

"We have to practice safe prescribing practices and monitor patients closely."

DR. SUNDER KRISHNAN, Pain Medicine services at Regional One Health

Dr. Stern: On one hand, we treat medically, mental and physical health. There's also the holistic view. The big thing we see is that the constellation of treatments is only partial if you don't treat the social aspects.

There's an acute need for housing, so patients don't go back to the same environment. And there's a need for workforce development and training. If there's no pathway forward, patients are entering a negative trajectory.

Collaboration is needed. We have a program with the police department—they send us people in trouble. But where do you house them? How do you get them into workforce development programs so they have a path forward? Do they have a license and transportation?

Lots of organizations won't hire you if you have a criminal record—you can't work in hospitals or government. And if the person doesn't have hope, that's a problem. There's a population like that in the inner city.

We need to have an impact on them—medical, mental and social determinants of health, focusing on housing and work. We need to consider the whole patient and change the long-term trajectory back into a constructive setting. We think of medical as no infections and no ER visits, but we also need to consider the legal and financial issues, social and family aspects, getting them back into the workforce. Wraparound services are important if you want change.

Dr. Krishnan: There are learned behaviors that people develop when it comes to taking pain medication. Patients have to realize that they play a key part in the improvement of their condition. They need to be accountable to comply with their treatment regimen. Lots of people aren't adequately educated about their condition—if we sit down and explain their condition adequately, and the pros and cons of the treatments they are being offered, a lot of them will listen to our guidance and be more compliant with their care.

Pitzer: We have a serious access issue in Memphis and Tennessee. If we have a patient with legitimate chronic pain it is very difficult to coordinate care and treatment; The Oaks doesn't provide services for chronic pain, but it comes up frequently. It's difficult to

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have those conversations.

Regional One is one of the few facilities we use for pain management. Access for those alternative treatment centers is difficult. It's easier for the patient to take a pill and not think about it.

Dr. Foley: Surgery is rarely the first approach to a pain condition with the broad exception of emergencies. Surgeries can have complications, be poorly performed, or have suboptimal outcomes. Patients who are confronted with the need for surgery may have talked with someone who had a bad outcome or read a story and be appropriately concerned. The key is to have the surgery done appropriately and in good hands.

The continued application of ineffective nonoperative treatment is equally problematic. Lets say a condition is worsening despite nonoperative management, including pain meds; if we continue that treatment it will produce bad outcomes as well. There needs to be a balance.

Crangle: How can practitioners and facilities collaborate to better help our population?

Smith: We're a behavioral health facility. Referral sources often stay involved with our kids to be part of child's aftercare process. We determine a treatment and discharge planning early on to address trauma and substance abuse needs.

With trauma and substance abuse, some kids have been struggling in school for a significant period of time. Maybe they have been expelled or they were doing online schooling, but not really effectively completing.

We work with families and other providers and key players to determine the next best key step. Is it a residential vocational plan? Alternative education plan? Intense outpatient treatment?

We look for the appropriate care plan when they discharge, so they're not stepping back into the same negative environment. There are risk factors when they're coming out of treatment. When you're 17 in 9th grade, then spend several months in treatment and the child is discharged—there's not a path to success for them.

We have to identify a successful discharge plan, which includes changing the environment and systems of care they're going back into. Just because someone is sober doesn't mean everything is resolved. They still need skills and support in other systems.

Dr. Stern: When chronic disease patients are discharged, they're vulnerable. When patients leave jail or a treatment facility, and they haven't had the same drug, they're vulnerable to overdose. Vulnerable people need a lot of guidance or they slip into the previous pattern.

We're not experts in creating jobs and workforce development or housing—it has to be collaborative. There's no one party that has all the requisite skills to help. There's a whole set of surrounding problems.

Pitzer: There's a lot of opportunity for collaboration. From formal collaboration of running programs together to informal collaboration that's relationship-based. And being involved in the community.

Lisa and I have cases where patients age out of her center at 18, but they still need care and are able to transition to an adult facility. We have a lot of opportunity for collaboration in Memphis; we have doctors and resources and a strong addiction community. Those relationships are important.

Dr. Krishnan: We need to utilize a multi-disciplinary approach, which we're doing at Regional One Health in the our multi-specialty clinic at our East Campus. This month we opened our pain treatment center within the clinic where we can address some of these issues, and we're working toward a plan to incorporate addiction medicine in the future.

We have to look at proper prescribing practices; there's a certain limit of pain meds that people can take before it can possibly start working in the opposite way. There are studies that show excessive pain medication can actually make patients hypersensitive to pain.

Joanna: From a business owner standpoint, what are some techniques or strategies to help alleviate challenges?

Dr. Stern: If employers don't consider that they have employees with these issues, they're ignoring the problem. Because we know that a certain percentage of the population does have these issues. Whether it's a huge company like FedEx or a small employer.

They should involve the Shelby County Department of Public Health. Companies should look at bringing into their facilities the county's program for prevention and education. And employers should learn Screening, Brief Intervention, and Referral to Treatment (SBIRT), a simple screening to identify if someone has a problem. We need more widespread recognition of problems.

There's a coercion program with airline pilots. If they show up with contaminated urine, they lose their license. What we deal with is harder, no one has that stick over the patients. We don't use coercion, we need persuasion and counseling. Each patient has to be treated differently.

Pitzer: We need to bring intervention education into the workforce. People are afraid to lose their job, so they're afraid to acknowledge their problem. Bringing resources to employers helps, so they know that if someone is impaired and needs treatment. We need this across the board, so employees are given a chance to get their life right.

Smith: With adolescents, research shows that a more direct, confrontational approach does not work. We don't talk about individual drug use. We look at the consequences and what they like about drug use. It's their survival tactic. Part of what they get from

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drugs meets their needs. We talk about the things that are meaningful that are contributing to drug use, triggers to that, how treatment has been impactful, where they want to go and how drug use will impact that.

Joanna: We've talked about timely and appropriate treatment. How does the persuasion conversation play into that?

Dr. Krishnan: We establish treatment goals. We follow protocols and the patient is educated on their condition; we review their imaging studies and explain that if nonoperative treatment doesn't work, we can refer them to a surgical specialist—who can hopefully help alleviate their pain.

Dr. Foley: It's not really a persuasion task but more of an education task. Often, patients have inadequate nonoperative care. Patients are referred to me because I'm a surgeon. When patients who are not ideal surgical candidates come to me for surgery, I'll explain and educate them why surgery is not the right option and refer them back to a nonoperative physician. We want to avoid Failed Back Surgery Syndrome.

Dr. Stern: Ten percent of patients who benefit from substance abuse treatment get it. We have a shortage of access to treatment and specialists. The truth is, a lot of people don't want to be treated or aren't ready.

We're starting a program with the police department and EMS, when they identify patients who are ready for treatment, it's their job to coax or persuade them into treatment. Persuasion is important. Someone who's ready will disappear if you don't get them right away. There's a key period when persuasion does have an important role.

Crangle: How does pain play a role in your practices and treatments?

Dr. Foley: One of the things that doctors have lived through in my generation is almost a complete reversal of the pain treatment paradigm. We were taught the notion of the fifth vital sign being pain; it was emphasized to all healthcare providers that pain needed to be treated as a priority.

Pain was quantified and was to be minimized. That concept led to lots and lots of overtreatment and the overprescribing of pain meds. It's one of the nagging issues that we deal with today because now society is dealing with the huge problem of pain medication overuse.

As practitioners, we now are faced with the notion that we need to stop providing potentially excessive pain medication. At Semmes Murphey, we're struggling to decide what we can give for post-operative pain. It's a significant change of approach to the problem that's been incompletely thought-out by government and organized medicine.

For example, if you have kidney stone pain, it's one of the most excruciating pains. Pain meds do have legitimate uses; without them humans suffer. Overuse is equally a problem. We have to find a balance. When someone is in lots of pain, of course we want to alleviate it, but we don't want to leave patients with a lifelong problem.

Dr. Krishnan: The fifth vital sign came at a time when oxycontin was hitting the market. Now, I concur with Dr. Foley. We have to decide who's legitime and who's not, when giving prescriptions.

This is where education comes in; there's a lot of expectation that people have to be given meds. I always think before I write a script—am I doing the right thing by giving pain meds to a patient or am I feeding habit?

Dr. Stern: The problem quickly traffics from post-op surgery pain meds to street heroine, which is cheap. If a doctor says a patient needs to taper the meds and the patient says no, they have another thing to turn to.

The prescription limitation that was passed by the Tennessee legislature is very good in trying to prevent this problem by limiting the amount of prescribed opioids, but it has to be coupled with treatment options. If there isn't an accessible wraparound treatment, they'll find another source. It is available on the streets in Memphis.

Crangle: Please share your closing thoughts.

Dr. Krishnan: The opioid crisis has an extensive implications to the community. It's is a problem that is affecting people of all socio-economic backgrounds. We need to do our best to address this.

Dr. Stern: The business community needs to be an active participant working on this problem. We don't have enough residential housing for people with this problem in a somewhat supervised environment. Housing is a critical missing gap. If the business community comes to the table with treatment providers and pain specialists, they can be contributors to a solution. It takes a village.

Smith: We have kids who age out of our program. We need to be able to find a place that provides support to them. Often times, we can identify alternative vocational or educational placements that can offer residential option to provide support and a structured setting. Our program has worked to build crucial relationships and collaborate with these programs to offer appropriate aftercare planning

Pitzer: It's a positive moment and opportunity now for long-term change around coordinating care for complex cases, ensuring access, and getting on the other side of the opioid crisis.

The government has commissioned a public/private partnership that brings the government and non-profits and for-profit businesses together for an open discussion about what the business community needs to do using all treatment modalities.

Spiritually, medically, cognitive behavioral work, primary care—a treatment plan for the state. We have an opportunity here.